Breaking the Boundary of Separatism: The Challenge for Health and Welfare Service Providers*

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You may have wondered about the particular relevance of the topic I have chosen to discuss with you at this Child Psychiatry Spring Forum. What, indeed, do separatism and boundaries have to do with providing services for children, and how closely related to child psychiatry is the broader area of health and welfare? I hope my remarks will show that these questions are critical; that they are pertinent not only to administrators, but that they *do* in fact have clear implications for those who treat children both directly and indirectly.

There are a number of issues identified with the area of services for children that point to the boundary problems of isolation, defensiveness, and a narrow view of the child and his family.

Perhaps the most perplexing of these is that of **technology.** The recently published critique of the Joint Commission on Mental Health Report, *Crisis in Child Mental Health*, by the Group for the Advancement of Psychiatry (2), points out a number of polarizing factors in the professional community. These include:

1. The interface between health and sickness, the medical vs. the non-medical model.
2. The prevention and treatment dichotomy.
3. The split forces of those working for children, from those working for adults, with a third group expressing commitment to programs for families.
4. Interdisciplinary competition.
5. Education and therapeutics.

Related to the knowledge base is the problem of **domain.** For example, in cases of combined emotional disorders and delinquent behavior or retardation and delinquent behavior, we see most clearly our treatment apparatus breaking down. The schools will not accommodate certain behavior, and they exclude the child from their educational responsibility. When a child displays disturbed behavior, the training center hesitates to fulfill its responsibility to resocialize the child. A treatment facility too often will draw the line on tolerant behavior depending on whether the child is sent by the court or by a therapeutic facility. I do not imply criticism here of any of the services systems; rather, I am attempting to describe what appears to occur in our services network, representing daily struggles familiar to all of us. In a real sense, a lack of substantial agreement on treatment models puts us into the posture of defending the decision-making procedures of our own agencies rather than accommodating the child through the maze of eligibility requirements, rules, and agency regulations. Can you wonder at any response other than the need for advocacy?

A third issue is simply the **lack of resources.** What, for example, are the treatment dimensions in Virginia? Our own treatment center is the only one of its kind in the State. A few private facilities exist but are generally inaccessable, and even those are not free of the limitations of technology and domain. The "case creaming" process is common. More serious than that, such transitional accommodations as basic receiving facilities, crisis centers, and temporary residences are badly lacking.

Taken together—our technology, organizational arrangements, and paucity of resources—we have in a nutshell the dilemma of serious needs not being adequately met.

The combination of these issues accounts for the myopia of our present services. The lack of

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meaningful strategies to get at such problems is a further symptom of our separatism posture.

In many ways there is a functional aspect to this "going it alone." It does provide a kind of autonomy in control and it minimizes interference—both from other service systems and from our own clients as well. This low visability profile is safer, more comfortable, and less harsh in light of the frustrations imposed by our limited knowledge (Are we honest enough about this?), our limited resources, and our perceived need to be protective of our own house.

I am afraid, however, that what might be short-range advantages turn to long-range disasters. For example, in our own State of Virginia the separatism philosophy of avoiding Federal monies for Mental Health and Mental Retardation Programs, has resulted in an unequal service system. Too much of our money has gone for institutions and too little for community programs. But it is worse than that, because even the community system we do have, that is, our State clinics, is limited in the services it provides. This lack of comprehensive community programs has led to inappropriate reliance on our institutions and the stunting of our growth potential, thus impeding the development of a proper partnership between our clinics and institutions. The after-care programs, which in this State are too exclusively oriented to drug monitoring, and the lack of unitization programs across the states are the consequences of foregoing a major national development. The implications of such inaction have affected not only services and training, but have, for some states, laid a foundation for taking advantage of new developments in education and training as well as resources. For example, if revenue sharing were a reality tomorrow, how quickly would we be able to move to make the case for its utility in mental health and mental retardation? I am afraid there are other agencies which might be able to move more adroitly because of their sophistication with data systems and research. They have experience that comes from interacting with other agencies as well as other levels of government. Isolationism and separatism are not conducive to posturing oneself for progress.

Why should a State half our size have a waiting list of five in a mental retardation institution while we have a list of 1,000 at one of our institutions. Obviously, such circumstances suggest an array of services that we cannot provide and do not provide—nursing homes, group homes, halfway houses, and the like.

We are beginning to reverse this situation, but the point is that we have lost untold opportunities from our refusal to engage in programs beyond state borders.

And what is the situation in Virginia? An official of one of the State agencies suggested to me recently that it has been nearly five years since his agency has interacted directly with another agency's central office. One might understand this if the objectives of these departments differed in terms of clientele, but very often, the client for more than one agency is the same person.

Looking at current state trends, one is impressed with some common patterns. Two of significance include:

1. Reorganization of state governments into super human-resource systems.
2. Class actions against state agencies in education, mental health, and mental retardation. These lawsuits in such states as Alabama, Massachusetts, Pennsylvania, and New York are involved with the issues of the right to education and the right to treatment.

The interesting dynamic of *both* of these activities is that dissatisfaction with the traditional state service system is being expressed in a loud and clear manner. On the one hand, its very organization is being changed, and on the other, it is being charged with delivering inefficient and ineffective services.

This is not the place to get into the substantive aspect of human resources reorganization, or the right to treatment and education. One can observe, however, that the tendency of service systems to be highly restrictive in their client selection and extremely selective in their coordinated activities suggests the posture of separatism I have been alluding to.

Now, however, with service systems being besieged by citizen's groups and professionals such as lawyers, the standard of care delivered by these traditionally autonomous operations is being brought into question. Common to this inquiry are:

1. What is the proper ratio of staff to patients?
2. To whom does the burden of proof belong when considering institutionalization?
3. Are legal rights being infringed by our treatment procedures?
4. Can a handicap disqualify a child from a public education?

The implications are indeed profound. Basic

education, for example, becomes intertwined with physical and emotional disabilities; patterns of care become multi-faceted so that community control enters the back ward of the State hospital. The community is being identified as the arena for comprehensive care.

It would appear that dealing with the client as defined by the services network will no longer be acceptable; rather, the needs of the client will determine how the services will be arranged.

Through all of this the traditional boundaries will no longer work. For one thing, the ability to control them has weakened. The increasing visibility of our care systems and professional behavior is apparent. The class actions alluded to above are one expression of community awareness; the de-institutionalization movement in corrections, mental health, and mental retardation is another. And finally, fiscal and organizational rearrangement through service intergration suggests that account-ability is being shifted to a larger constituency.

What then is one to make of all this? My own feeling is that our narrow focus, our preoccupation with our own system, has led us to the precipice of limited effectiveness. In attempting to shoulder all the responsibility, we have lost the sense of community, which as Charles Abrams has suggested, "is that mythical state of social wholeness in which each member has his place and in which life is regulated by cooperation rather than competition and conflict." He suggests further that, "it has had brief and intermittent flowerings through history, but always seems to be in decline at any given historical present. Thus, community is that which each generation feels it must rediscover and recreate" (1).

In conclusion, let me share with you two examples which represent our rediscovery of the community. Hopefully, they will demonstrate a beginning of our moving away from separatism toward "social wholeness."

The first is the concept that Dr. Robert Jaslow is developing at the Northern Virginia Training School for the Mentally Retarded. The major emphasis is one of engaging the community itself in the critical pathways of a training and rehabilitation center. Decisions of who should come in will come from the community residents themselves. Each element of the catchment area will have a certain number of beds available to it based on population representation. A committee of residents from each of the catchments will screen for entry and negotiate for exchange if no beds are available. It will not be a place to discard people. The expectation is that residency will not be permanent but transitional. And the residents-in-house will be seen in relationship to residents in the community. The training center is viewed as a part of the community; both in its sharing of hard decisions as well as in the openness of its living and training patterns.

The second example concerns a project we have requested Federal funds for—an integrated service system for deinstitutionalization. The project assumes that certain residents in our mental hospitals, retardation facilities, and correctional institutions do not belong there.

We will develop assessment and prescription teams for each of the three types of facilities. Membership will be taken from the staffs of the institutions as well as the appropriate agencies in the two target communities. Together they will evaluate the emotional, physical, social, and legal needs of each resident from the communities. Once identified, these needs will then be matched with the resources that are required. Another team will evaluate the adequacy and accessibility of these resources. If gaps exist and their pattern identified, they will be presented to a Committee of Commissioners. This committee will consist of the directors of each of the major State human resource departments. The heads of Education, Health, Mental Health, Vocational Rehabilitation, Welfare and Institutions, Commission on Children and Youth, Commission of the Visually Handicapped, Department of State Planning and Community Affairs, and the Employment Commission will see directly not only the gaps but also how they relate to the responsibility of each agency in providing services to the community. Clearly this will have implications for the committee members' ability to recognize priorities and the impact of that recognition on the problems that will be brought to their attention. Such a set-up will, one hopes, diminish the single track route and focus on the commonality of need, as well as the commonality of the agencies' responsibility. The convenience of separating the person into a behavioral disorder category and a delinquency category, for example, becomes secondary to the major consideration of a person with different problems.

We can see in the first example a partnership between the training center and its constituent community. In the second, we see a full systemic cycle of need, its accommodations, or lack of such, and the recognition of these arrangements by those responsible for obtaining resources and directing their utilization.

It seems to me that these approaches are conducive to dealing more positively with the problems of resources, the state of our technology, and our service structure.

In the end, the client is best served when our concerns transcend the system and focus on the people it was created to serve.

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